

**New Patient Information**

Full Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Preferred Name and/or Nickname: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_ Street Address: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Apartment #: \_\_\_\_\_

Email Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_, MI, \_\_\_\_\_

Job Title: \_\_\_\_\_ Employer: \_\_\_\_\_

*How did you hear about our office? (please check below)*

I was referred by \_\_\_\_\_, a  friend  family member  co-worker  
(Full Name of person(s) who referred you)

- |   |                                   |  |  |
|---|-----------------------------------|--|--|
| <input type="checkbox"/> Google             | <input type="checkbox"/> Postcard | <input type="checkbox"/> Bohn Dental Website | <input type="checkbox"/> Office Location |
| <input type="checkbox"/> Facebook/Instagram | <input type="checkbox"/> Magazine | <input type="checkbox"/> Insurance Company   | <input type="checkbox"/> In-Person Event |

**Dental Insurance Information**

Insurance Company: \_\_\_\_\_ Group/Plan #: \_\_\_\_\_

Do you have a Secondary Insurance Policy? (please circle) YES NO

*\* Please provide the following information ONLY IF the subscriber/policy holder is different than person above \**

Subscriber/Policy Holder Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Financial Responsibility and Assignment of Benefits:**

Our staff will do our best to provide accurate estimates of insurance remittance. However, all co-pays are estimated. It is important to understand your obligation is to pay for treatment in full, regardless of the amount that may or may not be reimbursed by your insurance company. Therefore, your estimated co-pay will be collected at time of service but an additional amount due could come as a statement to you after your insurance remits your benefits to our office.

We will bill your insurance company as a courtesy with your consent (as signed below). If your insurance company has not remitted payment within 90 days, you will be responsible for the account balance and must seek reimbursement from your insurance company.

If you are unable to fulfill your financial responsibility for a service, we do reserve the right to not perform the service.

I have read and accept the terms and conditions of my financial responsibility and this assignment of benefits agreement. I authorize my insurance company to pay my dental benefits directly to Bohn Dental PLLC and will inform them of any changes to my insurance policy. I understand that verifying my dental insurance is active at the time of every procedure/treatment is my personal responsibility.

Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**TUBERCULOSIS CHECK**

Please check if you have had any of the following diseases or health concerns:

- Active Tuberculosis
- Persistent cough lasting more than 3 weeks
- Been Exposed to anyone with Tuberculosis
- Cough that produces blood

**GENERAL HEALTH INFORMATION**

Preferred Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_ Street/City: \_\_\_\_\_

Medical Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Location: \_\_\_\_\_

*\*Please check "YES" or "NO" to the following health questions and provide additional details as needed\**

<b>Question</b>	<b>NO</b>	<b>YES</b>	<b>OTHER/NOTE:</b>
Are you in Good Health?			Please provide month/year of last exam:
In the past year, have there been any changes in your health?			If yes, please note condition being treated:
In the past 5 years, have you been hospitalized for a serious illness or operation?			If yes, please provide details of illness or surgery:
Are you currently taking any prescription or over the counter medicines/vitamins/supplements?			If yes, please list all:
Do you wear contact lenses?			
Have you had any orthopedic total joint replacement? (Including hip, knee, elbow, ankle, or finger)			If yes, please specify joint and date of surgery:
Are you taking or have you taken the medications Alendronate (Fosamax) or Risedronate (Actonel) for Osteoporosis or Paget's Disease?			If yes, please specify date treatment began:
Since 2001, were you treated or are you currently scheduled to begin treatment with I.V. bisphosphonate (Aredia or Zometa) for bone pain, hypercalcemia, or skeletal complications resulting from Paget's Disease, Multiple Myeloma, or Metastatic Cancer?			If yes, please specify date treatment began:
Do you use controlled substances? (drugs)			If yes, please specify substance:
Do you use tobacco? (smoking, snuff, chew, vape)			If yes, are you interested in stopping?
Do you drink alcoholic beverages?			If yes, how much in the last 24 hrs & average in a week?

**BELOW FOR WOMEN ONLY**

Are you currently or could you possibly be pregnant?			If yes, how many weeks?
Are you currently nursing?			
Are you taking birth control or hormone replacement?			

Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ALLERGIES**

*\*Please CHECK if you are allergic to or have had any reaction to the substances below: \**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Local Anesthetics                          | <input type="checkbox"/> Sulfa Drugs                | <input type="checkbox"/> Iodine              | <input type="checkbox"/> Other (please list below) |
| <input type="checkbox"/> Aspirin                                    | <input type="checkbox"/> Codeine or other Narcotics | <input type="checkbox"/> Hay Fever/ Seasonal | <input type="checkbox"/> _____                     |
| <input type="checkbox"/> Penicillin or Other Antibiotics            | <input type="checkbox"/> Metals                     | <input type="checkbox"/> Animals             | <input type="checkbox"/> _____                     |
| <input type="checkbox"/> Barbiturates, Sedatives, or Sleeping Pills | <input type="checkbox"/> Latex (Rubber)             | <input type="checkbox"/> Food                |  |

**CONGENITAL HEART DISEASE (CHD)**

*\*Please CHECK if you have had any of the following heart conditions or treatments: \**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Artificial (prosthetic) heart valve  | <input type="checkbox"/> Congenital heart disease (CHD)     | <input type="checkbox"/> Repaired CHD completely in the last 6 months |
| <input type="checkbox"/> Previous Infective Endocarditis      | <input type="checkbox"/> Unrepaired, cyanotic CHD           |   |
| <input type="checkbox"/> Damaged valves in transplanted heart | <input type="checkbox"/> Repaired CHD with residual defects |   |

**OTHER DISEASES AND CONDITIONS**

*\*Please CHECK if you have had or currently have any of the following conditions: \**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Cardiovascular Disease             | <input type="checkbox"/> AIDS or HIV  | <input type="checkbox"/> Thyroid Problems                                 |
| <input type="checkbox"/> Angina                             | <input type="checkbox"/> Arthritis  | <input type="checkbox"/> Stroke<br>(date: _____)                          |
| <input type="checkbox"/> Arteriosclerosis                   | <input type="checkbox"/> Autoimmune Disease   | <input type="checkbox"/> Glaucoma   |
| <input type="checkbox"/> Congestive Heart Failure           | <input type="checkbox"/> Rheumatoid Arthritis   | <input type="checkbox"/> Hepatitis, Jaundice, or Liver Disease            |
| <input type="checkbox"/> Damaged Heart Valves               | <input type="checkbox"/> Systematic Lupus   | <input type="checkbox"/> Epilepsy   |
| <input type="checkbox"/> Heart Attack<br>(date: _____)      | <input type="checkbox"/> Asthma   | <input type="checkbox"/> Fainting Spells or Seizures                      |
| <input type="checkbox"/> Heart Murmur                       | <input type="checkbox"/> Bronchitis   | <input type="checkbox"/> Neurological Disorders (specify below)<br>_____  |
| <input type="checkbox"/> Low Blood Pressure                 | <input type="checkbox"/> Emphysema  | <input type="checkbox"/> Sleep Disorder                                   |
| <input type="checkbox"/> High Blood Pressure                | <input type="checkbox"/> Sinus Trouble  | <input type="checkbox"/> Mental Health Disorders (specify below)<br>_____ |
| <input type="checkbox"/> Other Heart Defects                | <input type="checkbox"/> Tuberculosis   | <input type="checkbox"/> Recurrent Infections                             |
| <input type="checkbox"/> Mitral Valve Prolapse              | <input type="checkbox"/> Cancer/Chemotherapy/<br>Radiation Treatment<br>(date: _____) | <input type="checkbox"/> Kidney Problems                                  |
| <input type="checkbox"/> Pacemaker<br>(date: _____)         | <input type="checkbox"/> Chest Pain upon exertion                                     | <input type="checkbox"/> Night Sweats                                     |
| <input type="checkbox"/> Rheumatic Fever                    | <input type="checkbox"/> Chronic Pain   | <input type="checkbox"/> Osteoporosis                                     |
| <input type="checkbox"/> Rheumatic Heart Disease            | <input type="checkbox"/> Diabetes Type 1  | <input type="checkbox"/> Persistent Swollen Neck Glands                   |
| <input type="checkbox"/> Abnormal Bleeding                  | <input type="checkbox"/> Diabetes Type 2  | <input type="checkbox"/> Severe Headaches/Migraines                       |
| <input type="checkbox"/> Anemia                             | <input type="checkbox"/> Eating Disorder  | <input type="checkbox"/> Severe or Rapid Weight Loss                      |
| <input type="checkbox"/> Blood Transfusion<br>(date: _____) | <input type="checkbox"/> Malnutrition   | <input type="checkbox"/> Sexually Transmitted Disease                     |
| <input type="checkbox"/> Hemophilia                         | <input type="checkbox"/> Gastrointestinal Disease                                     | <input type="checkbox"/> Excessive Urination                              |
|   | <input type="checkbox"/> G.E. Reflux/ Persistent Heartburn                            |   |

**PREMEDICATION**

Has a physician or dentist recommended that you take antibiotics prior to every dental visit/procedure?

- No  Yes If yes, please provide name of physician/dentist and number: \_\_\_\_\_

**NITROUS FOR TREATMENT:** Do you prefer nitrous (laughing gas) for dental procedures?  No  Yes

**OTHER NOTABLE CONCERNS OR CONDITIONS:** \_\_\_\_\_

Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**HIPPA/ PATIENT PRIVACY ACT**

The Health Insurance Portability and Accountability Act requires that our office complies with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future. To comply with one of HIPPA's requirements, we are offering to provide you a copy of our Notice of Privacy Practices. Please let one of our administrative staff know if you would like to view and/or take home the copy of privacy practices.

We are also required to obtain your written consent and acknowledgement prior to disclosing any of your information except in connection with: defense to a claim challenging our professional competence; a review of practice's functions/transactions; a claim for payment of fees; a third-party payer's examination of our records; a court order as part of a criminal investigation; an identification of a deceased person; a licensure investigation; or a neglect/child abuse or domestic violence investigation.

It may be necessary for us to disclose your information in connection with your treatment; for example, a referral or consultation with another dentist or healthcare professional or providing material and case details to a laboratory.

If you have any other person(s) that you would like to grant permission for Bohn Dental staff to be able to discuss your treatment, appointments, finances, insurance, and/or diagnosis or concerns with, they need to be listed below:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

**LATE CANCELLATION OR MISSED APPOINTMENT POLICY**

One of the main benefits to a small family practice is the ability for us to prioritize our schedule. At Bohn Dental, we strive for every patient to be seen precisely at their appointment time and to provide enough time for treatment for our patients to feel comfortable and unrushed. As a single-doctor practice, we do not double-book appointments; if you have a reserved appointment time, our entire staff is waiting to greet you and provide a service specific to your needs.

At Bohn Dental, we do everything possible to make sure that we can see you on the days and times that work well for your schedule, as well as ours. Our team will provide reminders of your reserved appointments 3 weeks ahead of your appointment, 1 week ahead, and 3 days ahead; we will also call you the day before if we have not received a confirmation from you at your 3-day reminder. Please provide us with your preferred method of communication:

I would like TEXT message reminders       I would like phone CALL reminders

If you are unable to keep your reserved appointment time, please **provide 48-hour notice for rescheduling or cancelling**.

If you provide less than 48-hour notice to cancel or reschedule your appointment or if you fail to appear for your appointment, **a \$40 fee will be applied to your account** and payment will be required to be remitted before scheduling another appointment with our practice. Every patient will be provided with a one-time waiver of this fee to be utilized at their discretion.

We respect our patients and value our patient-provider relationship; it is because of this, that if more than 3 appointments are missed or cancelled with short-notice, that it will be at the discretion of Bohn Dental to excuse a patient from further care opportunities.

Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_